STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:

SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL

(X2) MULTIPLE CONSTRUCTION A. BUILDÌNG

F242

PRINTED: 06/24/2011 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

345051

B. WNG

PREFIX

08/10/2011

(X5) COMPLETION DATE

7/8/2011

NAME OF PROVIDER OR SUPPLIER

(X4) ID

PREFIX

ANSON COMMUNITY HOSPITAL SNF

STREET ADDRESS, CITY, STATE, ZIP CODE 600 MORVEN RD

WADESBORO, NC 28170

TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES	F 242	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the
	The resident has the right to choose activities, schedules, and health care consistent with his or		provider of the truth of the facts alleged or conclusions set forth in this

her interests, assessments, and plans of care; Interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.

This REQUIREMENT is not met as evidenced

Based on observations, record reviews, resident and staff interviews, the facility failed to honor the food preferences of 1 of 3 sampled residents reviewed for choices. Resident #69.

Findings included:

Resident #69 was admitted to the facility on 7/1/07 with diagnoses which included: cardiomegaly; vascular heart disease; coronary artery disease; hypertension; chronic anemia; osteopenia; and, depression.

Review of the annual Minimum Data Set (MDS) dated 3/3/11 indicated Resident #69 was cognitively intact, and was independent with eating requiring meal tray set-up help, only.

The Quarterly Dietary Assessment dated 5/20/11 revealed Resident #69 was to receive a 1500 calorie diet of regular consistency and was able to feed herself; but, generally would leave the meat/protein food uneaten. The resident also had a general dislike of alternates.

his litute this statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.

PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE

Resident #69 was immediately offered a substitute for the noodles that she received on her meal tray.

Tray cards for other residents having the potential to receive a "dislike" food will be checked prior to each meal by the dietary supervisor to insure that residents do not receive items of food that they have listed as a "dislike". In the event of an error, nursing staff will remove the food tray, dietary department will be notified, and a new food tray will be provided for the resident.

The Registered Dietician and Food Services Manager will review tray cards prior to each meal. If the food on the menu is one that the resident dislikes, the current tray card will be removed and a handwritten one will be placed on the serving line listing the food to be substituted for this meal.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made avaitable to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

ent ID: 161Z11

Facility ID: 952941

If continuation sheet Page 1 of 25

CENTERS FOR MEDICARE & MEDICAID SERVICES						OMID MC	7. 0830-0381
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	dining room eating lur beef macaroni, green meringue ple, and ice herself, but did not ea noodles. The resident like noodles and she il macaroni before and tike it. During this measomething else to eat that she was not hung green beans and ple. On 6/6/11 at 12:25pm Resident #69's Meal Comeal tray with her pla resident was not to re and no noodles or au Review of the "Food Foodles/pasta as a for #69. On 6/8/11 at 5:35pm, feeding herself in bed consisted of turkey, so cake, skim milk and ice she did not like noodles informed facility staff i receive noodles during merceive noodles no	lan (updated 6/1/11) 9 required set-up trays. ervation on 6/6/11 at 89 was observed in the main ich. The meal consisted of beans, a bread roll, lemon d tea. The resident fed t any of the beef macaroni revealed that she did not had been served beef told the staff that she did not had been served and stated ry. Resident #69 ate the the observation of Card, which was on her ted meal, indicated the ceive oatmeal at breakfast, gratin potatoes. Preferences" sheet included od item dislike of Resident Resident #69 was observed The resident's meal quash, noodles, marble ed tea. Resident stated that	L.	242	Continued from page 1	veloped that Meals (90) orted to y and to and Re- inpliance ome a Quality rogram	
	dld not want noodles						

	or pressientoro			111 700	N E CONSTONETION	(X3) DATE SUI	DVEA
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION	COMPLET	
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F 242 F 272	Continued From page noodles on the resided During an interview or revealed that she was documenting the resident did not like the resident did not like meals; and the resident, 483.20(b)(1) COMPR ASSESSMENTS The facility must conca comprehensive, accomprehensive, accomprehensi	nt's plate during this meal. n 6/8/11 at 5:45pm, the RD responsible for dents' food preferences. The stake had been made 39 as well as her family, that are or want noodles with her ant should not have received a should not have received	F	242		ements ed for nis with not regime ses and nt plan of odated have dents ssed by Team	7/8/2011
		nd structural problems; d health conditions; status;			The MDS Coordinator has cone education for the members of the interdisciplinary Care Plan Tearegarding the need to address areas of concern whether obserported by the resident and to these areas for	he m any rved or	

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULT DENTIFICATION NUMBER: A. BUILDR			PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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F 272	Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interview and staff interviews, the facility failed to complete an assessment for a resident with insomnia (Resident #43) and to complete an annual assessment (Resident #58) for 2 of 22 sampled residents. Findings include: 1. Resident #43 was admitted to the facility on 5/11/05 and re-admit on 1022/10. Diagnoses included; Hypertension, PVD (peripheral artery disease), Hypertipidemia, Cerebrovascular Accident, Depression, Below the Knee Amputee, Atherosclerosis and Chronic Kidney Disease. A review of the annual MDS (Minimum Data Set) dated 5/19/11 revealed resident had no memory problems and cognitive skills were intact. The functional status for dressing, eating, tollet use, personal hygiene, bathing and bed mobility required extensive assistance by 2 persons. The interview conducted for the residents mood		L.	272	Continued from page 3 discussion at the weekly Interdisciplinary Care Plan To Meeting. The MDS Coordinator or the Manager will, on a weekly ba the Interdisciplinary Care Plan Meeting, monitor to insure th areas of concern are address incorporated into the residen plan as appropriate. Documents monitoring will be maintal	city Plan Team or the Nurse Plan Team are Plan Team sure that all ddressed and Posident care	
			de de la constante de la const		will be shared with the Direct Nursing weekly and with the Quality Assessment and Ass Committee monthly. Resident #58 has had a comprehensive assessment completed, transmitted and a on 6/15/2011.	facility urance	
					A query has been completed confirm that residents in the thave had their MDS Assessment and in sequence of the MDS Coordinator will resident any changes required to resident condition or status implemented appropriately. A monthly query of the MDS will be completed to insure the resident assessments are contimely and in sequence.	acility nents ence. orrected. view the veekly to lired due s will be software at	

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F 272	revealed he had troub 2-6 days per week, fe energy 12-14 days (not concentrating on thing A review of the Care / (CAA) dated 5/19/11 of triggered and it indicated further review revealed findings' documented score increased over stated he has difficulty difficulty concentrating restlessness." This for completing a care plan of this score are care plan of the revealed to care plan of the revealed of the nurses basement period of 5/1/11 at 3:11pm of the revealed no document sleep patterns. On 6/7/11 at 3:11pm of the nurses basement period of 5/1/11 at 3:30pm of the nurses aide) who rout Resident #43 revealed improvement since additional difference and the respondence of the respondence	elle falling or staying asleep elling tired or having little early every day), and trouble gs 2-6 days Area Assessment Summary revealed that Mood was ted no care plan completed. ed the area tilled 'analysis of that "triggered due to total previous review. Resident y sleeping, is tired with g with period of rm also indicated no for m with a rational of "will not as factors which increased med in other areas." entation of an assessment is or conclusion regarding ting, being tired with g and periods of s' notes during the 6/11 through 6/19/11 tation regarding residents esident was observed lying if he would consent to an ed "I do not want to talk the anap." un interview with NA#1 tinely provides care for		272	Continued from page 4 The MDS Coordinator or the N Manager will, on a weekly bas the Interdisciplinary Care Plan Meeting, monitor to insure that areas of concern are addresse incorporated into the resident plan as appropriate. Documer this monitoring will be maintain will be shared with the Director Nursing weekly and with the fa Quality Assessment and Assur Committee monthly.	is during Team all all ad and care ntation of ned and r of	

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F 272	nap almost every after On 6/9/11 at 4:00pm as who completed the Carevealed the residents sleeping." Nurse #3 recurrent CAA and confiassessment for the recomplete to talk for a minus sleep at night, the resident #43 that he wanted to agreed to talk for a minus sleep. I am awake 2-2 sleep well last night a morning." 2. Resident #58 was diagnoses which inclucere brovascular accide paraplegia; spastic congitated features; diation congestive heart failured the review of the clinic was no comprehensive #58's functional capacity most recent annual Minus the resident was composite facility's records confirmed the facility annual MDS during the On 6/6/11 at 4:44pm, asleep, lying in a fetal resident made a continuation.	an interview with Nurse #3 AA Summary of 5/19/11 s "main problem was eviewed the residents firmed there was not an sidents inability to sleep. In an interview with Resident take a nap, however inute. When asked how well response was "I just can not to nights a week. I did not and was sleepy this admitted on 5/16/06 with aded: multiple tents; hypertension; antracture; dementia with betes mellitus and, re. ical records revealed there re assessment of Resident bity and health status. The inimum Data Set (MDS) for pleted in 2009, Upon review s, the MDS Coordinator had not completed an		272			

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	in her room, asleep in resident's hands and I During an interview or MDS Coordinator revenot placed on the rout when the resident was to the facility in Octobro for the Medicare 5 day completed; but the resoverlooked.	a reclined geri-chair. The egs were contracted. n 6/8/11 at 9:30am, the ealed that Resident #58 was ine MDS schedule because a hospitalized and returned er 2010, she only qualified assessment which was sident's annual MDS was	F 279 F279 Comprehensive Care Plans		7/8/2011		
	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprohensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced				Resident #48 has had her ris addressed in her plan of care measureable goals are included Resident #26 has had her ris falls addressed in her plan of measurable goals are included Resident #43 has had an every by his attending physician resident interventions have been included plan of care. Resident #58 has been screet the Speech Therapist and he aspiration have been addressed plan of care. Care plans for all residents hereviewed to insure that goals measurable and that all areas	sk for falls e and ded. sks for f care and ed. eluation garding nd non- een led in his ened by er risks for sed in her ave been are	

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F 23	Based on record revifacility failed to develumeasurable objective needs, failed to develume of 22 sampled resid #43, and #58). Findings include: 1. Resident # 48 was 12/15/08 with diagnost Hypertension, Anxiety 4/22/09 had a diagnost hypertension, Anxiety 4/22/09 had a diagnost hypertensive assistance mobility and had not the walked in the previous revealed that Resider previous assessment. Assessment dated 6/2 Resident #48 had a high Review of the Care Plans for fails secondary to assistance with transform "Resident will have recover the next review." On 6/8/2011 at 3:54 p Care Plans, Nurse #1	lew and staff interview, the op a care plan with s to meet residents' fall risk op a care plan for a resident and failed to develop a care ident's risk for aspiration for lents (Residents #48, #26, admitted to the facility ses that included r., Alzhelmer's, and on sels of Dementia with and the session of Dementia with and the session of the session	F 279	Continued from page 7 concern have been addressed Interdisciplinary Care Plan Telegarding the need to address areas of concern whether obsteported by the resident and these areas for discussion at weekly Interdisciplinary Care Team Meeting including goals are measurable. The MDS Coordinator or the Manager will, on a weekly baseduring the Interdisciplinary Care Manager will, on a weekly baseduring the Interdisciplinary Care and incorporated into the residual areas of concern are addressed in and that goals are measurable be maintained and will be shatthe Director of Nursing weekly with the facility Quality Assessed and Assurance Committee more	am. nducted the am s any erved or o present the Plan which Vurse sis, re Plan ure that essed dent care urable, ring will red with y and ement	

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F 279	2. Resident # 26 was re-admitted 12/1/2010 included Congestive included	admitted on 2/15/07 and admitted on 2/15/07 and admitted feart Fallure, Hypertension, Amputation and Lung and on Hospice on terly Minimum Data Set indicated that Resident dent on one person for appendent on two persons for hygiene. The MDS also at #26 did not get out of bed as. Furthermore, the MDS in on falls since the last and dated 1/28/10 and aled a problem for any the potential for falls in mobility (requiring total area), a history of falls, and The Goal read "Resident for falls daily over the next on the Nurse responsible for admitted in an interview al related to potential falls not measurable,	F 27		NO.1		

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 279	Accident, Depression Atherosclerosis and C A review of the annual dated 5/19/11 revealed problems and cognitive functional status for depresonal hygiene, bat required extensive as interview conducted for revealed he had troub 2-6 days per week. A review of the Care / (CAA) dated 5/19/11 triggered and it indica Further review revealed findings' documented score increased over stated he has difficulty difficulty concentrating restlessness." This for completing a care plan of this score are care plan was no documentation causes, risk factors or inability to sleep result difficulty concentrating restlessness. A review of the current date of 6/1/11 did not	Below the Knee Amputee, Chronic Kidney Disease. If MDS (Minimum Data Set) and resident had no memory we skills were intact. The ressing, eating, toilet use, hing and bed mobility sistance by 2 persons. The part the residents mood alle falling or staying asleep. Area Assessment Summary revealed that Mood was ted no care plan completed, and the area tilled 'analysis of that "triggered due to total previous review. Resident and seeping, is tired with a with period of the area tilled increased and in other areas." There is a factors which increased and in other areas." There is of an assessment for conclusion regarding ting, being tired with and periods of	F	279			

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F 279	revealed no document sleep patterns. On 6/7/11 at 3:11pm in bed. When asking interview, he respond right now. I want to tate of the control	resident was observed lying of he would consent to an ed "I do not want to talk ke a nap." an interview with NAI/1 thinely provides care for do he had shown imission. The resident does before, but he does take a rnoon. an interview with Nurse #3 AA Summary of 5/19/11 eresidents "main problem of not care plan it because it area's." Nurse #3 reviewed care plans and confirmed into in any care plan related into take a nap, however inute. When asked how well esponse was "I just can not a nights a week. I did not not was sleepy this admitted on 6/16/06 with inded: multiple lents; hypertension; intracture; dementia with petes mellitus and,		279				

TO F DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION LENGTHON NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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Review to the Speech Screen dated 3/2/11 received a pureed die resident continued to posture with no signific condition. Speech The this time. Review of the most repair of the MDS and long with severely impaired the MDS revealed the dependent on staff for and swallowing problem. In reviewing the Nursi indicated that Resider and swallowing food, resident was unable to in a noted loss of liquid or drinking. The review of the Spectreatm dysfunction and/or or was to be evaluated for bedside. The Goal of Caregivers/staff to de caregivers/training of a compensatory feeding oral care methods to it safety with by mouth in the control of the caregiver of the safety with by mouth in the caregiver of the caregiv	a Language Pathology revealed Resident #58 at assisted by staff. The have an open mouth icant changes in her erapy was not indicated as excent quarterly Minimum at 3/24/11 indicated Resident ag term memory problems at decision-making skills. er estident was totally reating; and had chewing ems. Ing Notes, documentation at #58 had difficulty chewing The records revealed the octose her mouth resulting ids from mouth when eating each Therapy Plan of //11 indicated Resident #58 ent for swallowing al function for feeding; and or swallowing function at her the therapy was: monstrate appropriate espiration precautions, g strategies, positioning and increase the resident's intake.	F 279			
	CONTECTION SUMMARY STA (EACH DEFICIENCY REGULATORY OR IS Continued From page Review to the Speech Screen dated 3/2/11 received a pureed die resident continued to posture with no signific condition. Speech The this time. Review of the most re Data Set (MDS) dated #58 had short and lor with severely impaired The MDS revealed th dependent on staff for and swallowing proble In reviewing the Nursi indicated that Resider and swallowing food, resident was unable t in a noted loss of liqui or drinking. The review of the Spe Treatment dated 4/15 was to receive treatm dysfunction and/or or was to be evaluated f bedside. The Goal of Caregivers/staff to de caregiver/training of a compensatory feeding oral care methods to safety with by mouth There was no evident developed by the faci	CORRECTION JA5051 JAFF COMMUNITY HOSPITAL SNF SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 11 Review to the Speech Language Pathology Screen dated 3/2/11 reveated Resident #58 received a pureed diet assisted by staff. The resident continued to have an open mouth posture with no significant changes in her condition. Speech Therapy was not indicated as this time. Review of the most recent quarterly Minimum Data Set (MDS) dated 3/24/11 indicated Resident #58 had short and long term memory problems with severely impaired decision-making skills. The MDS revealed the resident was totally dependent on staff for eating; and had chewing and swallowing problems. In reviewing the Nursing Notes, documentation indicated that Resident #58 had difficulty chewing and swallowing food. The records revealed the resident was unable to close her mouth resulting in a noted loss of liquids from mouth when eating	CONTIDER OR SUPPLIER OMMUNITY HOSPITAL SNF SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 11 Review to the Speech Language Pathology Screen dated 3/2/11 revealed Resident #58 received a pureed diet assisted by staff. The resident continued to have an open mouth posture with no significant changes in her condition. Speech Therapy was not indicated as this time. Review of the most recent quarterly Minimum Data Set (MDS) dated 3/2/111 indicated Resident #58 had short and long term memory problems with severely impaired decision-making skills. The MDS revealed the resident was totally dependent on staff for eating; and had chewing and swallowing problems. In reviewing the Nursing Notes, documentation indicated that Resident #58 had difficulty chewing and swallowing food. The records revealed the resident was unable to close her mouth resulting in a noted loss of liquids from mouth when eating or drinking. The review of the Speech Therapy Plan of Treatment dated 4/15/11 indicated Resident #58 was to receive treatment for swallowing dysfunction and/or oral function for feeding; and was to be evaluated for swallowing function at her bedside. The Goal of the therapy was: Caregivers/training of aspiration precautions, compensatory feeding strategies, positioning and oral care methods to increase the resident's safety with by mouth intake. There was no evidence that a Care Plan was developed by the facility to address Resident	SOURCE OR SUPPLIER COMMUNITY HOSPITAL SNF SUMMANY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FILL REGULATORY OR LSC IDENTIFYING INFORMATION) CONTINUED From page 11 Review to the Speech Language Pathology Screen dated 3/2/11 revealed Resident #58 rocolved a pureed dlet assisted by staff. The resident continued to have an open mouth posture with no significant changes in her condition. Speech Therapy was not Indicated as this time. Review of the most recent quarterly Minimum Data Set (MDS) dated 3/24/11 indicated Resident #58 had short and long ferm memory problems with severely impaired decision—making skills. The MDS revealed the resident was totally dependent on staff for eating; and had chewing and swallowing problems. In reviewing the Nursing Notes, documentation indicated that Resident #58 had difficulty chewing and swallowing food. The records revealed the resident was noted to close her mouth rosulting in a noted loss of liquids from mouth when eating or drinking. The review of the Speech Thorapy Plan of Treatment dated 4/16/11 indicated Resident #58 was to receive treatment for swallowing dysfunction and/or oral function for feeding; and was to be evaluated for swallowing unction at her bedside. The Goal of the therapy was: Caregiver/Fatafit to domonstrate appropriate caregiver/Fatafity to address Rosident There was no evidence that a Care Plan was developed by the facility to address Rosident	COMPLETION STREET ADDRESS, CITY, STATE, ZIP CODE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345051	B. WIN	G		06/1	0/2011
	NAME OF PROVIDER OR SUPPLIER ANSON COMMUNITY HOSPITAL SNF			50	REET ADDRESS, CITY, STATE, ZIP CODE 00 MORVEN RD VADESBORO, NC 28170		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 279	as a late entry for 4/14 Clarification order: Respeech therapy service week for dysphagia	ated 4/21/11 documented 1/11, a Speech Therapy Isident #58 was to receive Ites 5 times per week for 1 Ith focus on diet/liquid Ith stategies, aspiration Ith methods and discharge Resident #58 was observed Ither right side in a fetal Ith was making a continuous Ither mouth. In 6/8/11 at 3:25pm, Nursing Itevaled that Resident #58 Ith was making a continuous Ither mouth would hang Itherapy in the stance with feeding of Itherapy in the food/liquid spilling from Itherapy in 6/9/11 at 5:10pm, the Itherapy in the resident's risk of Itherapy in 6/9/11 at 5:11pm, the Itherapy in 6/9/11 at 5:11pm in 6/9/11 at 5	F	279			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

S FOR MEDICARE &	MEDICAID SERVICES			OMB NO.	<u>. 0938-0391</u>
OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		(X3) DATE SURVEY COMPLETED	
		A BUILDING	And the second s		
	345051	B. WING		06/10	/2011
OVIDER OR SUPPLIER		STR	EEY ADDRESS, CITY, STATE, ZIP CODE		
MMIINITY HOSPITAL S	NF				
		V	WADESBORO, NC 28170		
(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	DBE	(X6) COMPLETION DATE
Continued From page	13	F 279			
12:50pm, Resident #8 in bed being fed, by a pureed food items an also in the resident's guidance to the nursh service. There was n resident coughing or 483.20(k)(3)(i) SERVI PROFESSIONAL ST. The services provided must meet profession. This REQUIREMENT by: Based on observation and staff interviews, to medication in a safe is medication administration (Resident #24 & #45). Findings include: A review of the facility Administration of Ora 38.1 with a date of iss Reviewed/Revised: 7.10/07, 10/08, 11/08	is was observed sitting up nursing assistant, a meal of dithin liquids. NA#1 was room, giving verbaling assistant during the meal or observation of the choking during the meal. CES PROVIDED MEET ANDARDS If or arranged by the facility all standards of quality. Is not met as evidenced in, review of facility policy the facility failed to handle ranitary way for 1 of 2 allon observations. If (PO) Medication 1, Number the policy handle is an and room of the policy listration of oral medication one should never be ge or bottle once they have ose should be properly introlled substance follow	F 281	Medications Nurse #2 received on-the-spot counseling and education on the facility's policy and procedure regarding medication administration by the Director of Nursing. The medication for this resident immediately removed from the medication cart by the Director Nursing and replaced by the pharmacy. Nurse #2 received spot counseling and education regarding the facility policy and procedure for medication administration, by the Director Nursing. Licensed Nurses have been obtaining medication administration and deficient practice observed.	ation, t was of on-the- of served on and was	7/8/2011
	DVIDER OR SUPPLIER DMMUNITY HOSPITAL S SUMMARY STA (EACH DEFICIENCY REGULATORY OR I Continued From page During a dining obser 12:50pm, Resident #8 in bed being fed, by a pureed food items and also in the resident's i guidance to the nurshir service. There was n resident coughing or of 483.20(k)(3)(i) SERVI PROFESSIONAL STA The services provided must meet profession This REQUIREMENT by: Based on observation and staff interviews, ti medication in a safe s medication administra (Resident #24 & #45) Findings include: A review of the facility Administration of Oral 38.1 with a date of iss Reviewed/Revised: 7, 10/07, 10/08, 11/08, 1 Included in the admin policy was "Medicati returned to the packa been removed. The d destroyed and if a cor proper procedure for	ONMUNITY HOSPITAL SNF SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 13 During a dining observation on 6/10//11 at 12:50pm, Resident #58 was observed sitting up in bed being fed, by a nursing assistant, a meal of pured food items and thin liquids. NA#1 was also in the resident's room, giving verbal guidance to the nursing assistant during the meal service. There was no observation of the resident coughing or choking during the meal. 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy and staff interviews, the facility failed to handle medication in a safe sanitary way for 1 of 2 medication administration observations. (Resident #24 & #45)	PEPEICIENCIES CORRECTION OXIDER OR SUPPLIER DIMMUNITY HOSPITAL SNF SUMMANY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 13 F 279 Continued From page 13 During a diining observation on 6/10/11 at 12:50pm, Resident #58 was observed sitting up in bed being fed, by a nursing assistant, a meal of pureed food litems and thin liquids. NA#1 was also in the resident's room, giving verbal guidance to the nursing assistant during the meal service. There was no observation of the resident coughing or choking during the meal. 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy and staff interviews, the facility failed to handle medication in a safe sanitary way for 1 of 2 medication administration observations. (Resident #24 & #45) Findings include: A review of the facility policy titled 'Administration of Oral (PO) Medication', Number 38.1 with a date of issue 7/03 and Reviewed/Revised: 7/04, 10/04, 10/05, 10/06, 10/07, 10/08, 11/08, 11/09 was completed. Included in the administration of oral medication policy was "Medications should never be returned to the package or bottle once they have been removed. The dose should be properly destroyed and if a controlled substance follow proper procedure for disposal. Nurse should	PROPERCIONS OTHER REQUIREMENT OF DEFICIENCIES CONTINUED FROM BUSINESS AND SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. The services provided or arranged by the facility must meet professional standards of quality. The services provided or arranged by the facility must meet professional standards of quality. The services provided or arranged by the facility must meet professional standards of quality. The services provided or arranged by the facility must meet professional standards of quality. The services provided or arranged by the facility must meet professional standards of quality. The services provided or arranged by the facility must meet professional standards of quality. The services provided or arranged by the facility professional standards of quality. The services provided or arranged by the facility professional standards of quality. The medication for this residen immedication in a safe sanitary way for 1 of 2 medication administration observations. (Resident #24 & #45) Findings include: A review of the facility policy titled 'Administration of Oral (PO) Medication ', Number 33.1 with a date of issue 703 and Reviewed/Revised: 7/04, 10/04, 10/05, 10/05, 10/05, 10/07, 10/00, 11/09,	PREDICTION OF THE PROPERTY OF

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OWR M	<u> </u>
	OF DEFICIENCIES F CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SU COMPLET	
		345051	B. WI	B. WNG		06/1	0/2011
NAME OF PR	ROVIDER OR SUPPLIER		1	STR	EET ADDRESS, CITY, STATE, ZIP CODE		
Alicolia	ONE HODDIEN C	.xer		600 MORVEN RD			
ANSON C	OMMUNITY HOSPITAL S	OME		WADESBORO, NC 28170			:
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X6) COMPLETION DATE
F 281	Continued From page	14	F	281	Continued from page 14	,	
	contact with medication				The Medication Administration	Policy	
			į		and Procedure has been review		
		m Nurse #2 was observed			with the Licensed Nurses who		
		lavix) onto the top of the			been re-educated on this Polic		
		nurse picked up the pill with			Procedure including appropriat		
		on her fingers and placed allon cup filled with other			Infection Control practices whe		
		edication cart had spilled			administering medication. Eac		
		ill was dropped. During the			has been given a copy of the P	olicy.	
	observation of prepari				Pharmacists and Nurse Manag	ore will	
		se did not clean the top of			conduct random medication pa		
		f. The dropped pill along			weekly over the next three mor		
		was observed on 6/8/11 at	-		utilizing the Quality Assessmer		
	9:30am being given to	Resident #24.			Assurance tool that has been o		
	On 8/9/11 at 11:30am	an Interview with Nurse #2			to insure that nurses are follow		
}		dropped the Plavix on the			correct policy and procedure. I		
		cart but felt it was a clean			nurses, at a minimum will be ol	oserved	
	area and that it was a	Il right to give it to the			weekly.		
	resident.				A		
	A A A A A A A A A A A A A A A A A A A				Any deficient practices observe		
		n Nurse #2 was observed			during the medication pass will		
'		on (Lopressor) and placing it er hands and removing the			corrected immediately, followed nurse receiving on-the-spot	a by the	
		er it was cut with out any			counseling. The facility will foll	OW.	
	type of protective barr				progressive disciplinary policy		
	fingers. The nurse pla				and including termination for ar		
		edication cup and the other	-		who consistently fails to adhere		
		rned to the bottle of pills		į	policy.		
	(Lopressor) it had bee	n removed from.					
	On 010144 =1 34-00	a Antoniona data e Secretion			The results of these medication		
		a telephone interview with It she was trained to throw			observations will be shared with		
	out the other half of a				Director of Nursing weekly and		
	broken in half. "I gues				the facility Quality Assessment		
		realed that she felt if her			Assurance Committee monthly		
		could handle medication			three months of sustained com	pliance,	
		arrier on her hands/fingers.					

	of Deficiencies Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X?) M A. BUII		PLE CONSTRUCTION	(X3) DATE SU COMPLET	
		345061	B, WIN	IG		06/1	0/2011
	ROVIDER OR SUPPLIER OMMUNITY HOSPITAL S	NF.		δ1	eet address, city, state, zip code 00 morven RD Vadesboro, NC 28170		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Atement of deficiencies Y must be preceded by full SC identifying information)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 281	3. On 6/8/11 at 10:30 tearing a package corplaced the plll into the The nurse stated "my was observed placing out any time for the set the packing placing the packing placing the hand. She then dropp cup along with other p#24. On 6/8/11 at 11:10 am (Director of Nursing) rebroken half of the Lop bottle. At 2:25pm on 6 bottle of Lopressor hareturn of pills into the 6/9/11 at 11:30 am interevealed that she felt was all right to handle barrier on her hands/fi	am Nurse #2 was observed ntaining a pill (Flagyt) which bare hands of the nurse, hands are clean." Nurse #2 sanitizer on her hands with antitizer to dry before tearing the pill on to the palm of her ed the pill into a medication pills and gave it to Resident a discussion with the DON the egarding returning the ressor back to the original \$18/11 the DON stated the doesn discarded due to the bottle.		281	Continued from page 15 this tool will become a permane of the facility Quality Assessment Assurance Program.		7/8/2011
· SS=D	IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff				Resident #58 has been re-evaluely the Physical Therapist and recommendations have been mesonable party refuses to have resident participate in a therapy nursing restorative program as have chosen for staff to provide comfort measures only. The At Physician has been notified and response has been documented medical record. Resident #96 has been re-evaluer.	ade. or a they tending I this d in the	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	S FUR MEDICARE &	MEDICAID SEKAICES				OMD M	7. 0930-0391
	of deficiencies Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	(X2) MULTIPLE CONSTRUCTION A. BUILOING		(X3) DATE SU COMPLET	
		345051	B. WIN	IG		06/1	0/2011
NAME OF PR	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		
ANSON C	OMMUNITY HOSPITAL S	NF		500 MORVEN RD			
4		· · · · · · · · · · · · · · · · · · ·		V	VADESBORO, NC 28170		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 318	restorative services for as recommended by to 2 of 3 sampled resi (Residents #58 and #Findings included: 1. Resident #58 was diagnoses which includerebrovascular accidentable gia; spastic congestive heart failures.	sility failed to provide the s for range of motion exercises by the rehabilitation department residents with contractures. d #96). The second of the second		318	by the Physical Therapist and has been treated by therapy for two weeks at which time they transitioned to Restorative Nursing. Resident #96 is now receiving Restorative Nursing. Residents with referrals to Restorative Nursing in the past 12 months have been reviewed to insure that appropriate Restorative Nursing Programs have been implemented. The Nursing Administration Team and Therapy have been educated by the Director of Nursing regarding the revised referral process which includes		
	Physical Therapy Schoolconcluded therapy evidue to no change in Fistatus; the resident's livere at baseline. The that the resident begather program on 3/3/11. The Review of the "The Communication" form Nursing Assistant (RN training program by the providing Resident #5 range of motion (kneet kneets then how to possible the form on 3/3 Review of the most reduced the pata Set (MDS) dated	eens dated 3/3/11 eluations were not indicated tesident #58's functional bilateral knee contractures documentation indicated in the Restorative Nursing therapy to Nursing lindicated a Restorative IA) completed a caregiver e Physical Therapist on 8 gentle passive knee e straightening) on both sition her legs straight with upleted the training and			timely and appropriate communications for Restoral Programs. Therapy referrals to Restorative Nursing will be audited by the Manager on a weekly basis to that recommendations are followed and appropriate Restorative Pare implemented. Results of the monitoring will be shared with Director of Nursing weekly and the facility Quality Assessment Assurance Committee monthly	re Nurse insure owed rograms this I with	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION		(3) DATE SURVEY COMPLETED	
		345051	B. WNG		06/1	0/2011	
	ROVIDER OR SUPPLIER OMMUNITY HOSPITAL S	NF	ē	REET ADDRESS, CITY, STATE, ZIP CODE 600 MORVEN RD NADESBORO, NC 28170			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE.	(X5) COMPLETION BATE	
F 318	with severely impaired. The MDS revealed the dependent on staff for and had range of mot upper and both lower was not receiving any services. Review of the Care Plupdated 5/2/11 reveal impaired mobility and further contracture dedecreased range of motion for 6-7 days each week; if defor screen; and apply checking every shift for Restorative Nursing withese approaches. There was no docume Resident #58 received 3/3/11 through 5/4/11. comfort care on 5/4/11. The monthly Physician 2011 and May 2011) if "may evaluate and pla Program(s) as approp	d decision-making skills. e resident was totally r all Activities of Daily Living ion impairments in both extremities. The resident therapy or restorative an dated 3/30/11 and led Resident #58 had was at an increased risk of velopment secondary to a lotion. Approaches to this live range of motion or on to left wrist 15 minutes lek; gentle passive range of repeating 5 times for 6-7 cline noted, refer to therapy a hand roll to left hand or proper placement. leas to be responsible for entation available indicating if Restorative Nursing from The resident #58 included: loce in Restorative Nursing riate". listration Records (April June 2011) included as t #58: "Hand roll in left hand	F 318				

STATEMENT OF AND PLAN OF C	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345051	B. WIN	IG		06/1	0/2011
	VIDER OR SUPPLIER MMUNITY HOSPITAL S	NF		б	REET ADDRESS, ČITY, STATE, ZIP CODE 600 MORVEN RD NADESBORO, NC 28170		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	łΧ	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JI.D BE	CONSTELLON (X2)
ERD film Cahhh pN re DT h n n si m th DA re m aich re re h h R	Resident #58 was obsorble arms bent toward isted, and both legs between no splint devices on 6/8/11 at 8:53em, in reclined geri-chair intends were in tight fisher legs were bent/dresident geri-chair in tends were in tight fisher legs were bent/dresident's hands. During an interview on treatment Nurse reventated that when she controlled on the handrolls on the handrolls were in pouring an interview on the handrolls were in pouring an interview on the handrolls were in pouring an interview on the handrolls were in pouring care due to come the handrolls were in pouring an interview on the handrolls were in pouring an interview on the handrolls were to cand both legs at the knowled wash cloths were ands every morning the pestorative nursing assessiont for 8 hours the everaled that she was androlls were to remeate the start we hard an interview on the storative Nurse states.	n on 6/6/11 at 4:42pm, served asleep in bed with dis chest, left hand tightly sent towards chesf. There is noted. Resident #58 was asleep in her room. The resident's its against her chest; and awn upward in a fetal on a pillow. The Treatment oths in both of the 16/8/11 at 9:00am, the aled Resident #58 should at all times, and whenever the nursing assistants or aplaced them. She also did treatment rounds every neck the resident to ensure olace. 16/8/11 at 3:07pm, Nursing evealed that Resident #58 ion exercises during ontractures of her left hand nees. NA#1 stated that e placed in the resident's oy a nursing assistant or a sistant and remain on the en removed. NA#1 later	<u></u>	318			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	ultipi Lding	LE CONSTRUCTION	(X3) DATE SU COMPLET	
		345061	B. WIN	IG		06/1	0/2011
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				W	ADESBORO, NC 28170		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CONREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 318	Continued From page	. 19		318	,		
	not been in Restorativ		'	310			- Address
	Director of Nursing re Restorative Nursing A	n 6/9/11 at 5:05pm, the vealed that one of the assistants informed her that bived restorative range of lower extremities in					
	facility's Rehabilitation process for referrals to week before a resident therapy; the restorative trained on the ther Upon completion of the written referral with the	re nursing assistant would apy/restorative program. ils caregiver/aide training, a e restorative nursing would be sent to the nurse in					
3		llitus; pseudobulbar	- 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1				
	Resident #96's increa	dated 1/25/11 indicated sed passive range of extremities has decreased					
	Nursing Assistant (RN training program by the	nerapy to Nursing Indicated a Restorative IA) completed a caregiver e Occupational Therapist Resident #96 with passive					

STATEMENT OF DEFICIENCIES DESTRICTION DESTRICTION NUMBER:  AND PLAN OF CORRECTION  NAME OF PROVIDER OR SUPPLIER  ANS ON COMMUNITY HOSPIYAL SNF  AND SUMMARY STATEMENT OF DEFENDACES BOOK NOW AND SUMBERS, CITY, STATE, JUP CODE SOME MORE OR SUPPLIER  AND SOME COMMUNITY HOSPIYAL SNF  STREET ADDRESS, CITY, STATE, JUP CODE SOME MORE AND ADDRESS OF THE APPROPRIATE AND COMMUNITY HOSPIYAL SNF  WADESHORD, NC. 28170  PROVIDER OR THE APPROPRIATE COMMENTED BY FILL ACCOUNT OF THE APPROPRIATE COMMENTARY OF THE APPROPRIATE COMM	~~~ 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	O I OIT HILDROMINE OF	MEDIOVID OFIVATORO				OMILITA	J. 0000 O00 I
NAME OF PROVIDER OR SUPPLIER  ANSON COMMUNITY HOSPITAL SNF    Cost   ID   PREPRIX   CARD DEFICIENCY INSET BE PRECEDED BY FULL   TANK				1, ,	]' '			
ANSON COMMUNITY HOSPITAL SNF  (A) ID SUMMARY STATEMENT OF DEFICIENCIES (CACH DEFICIENCY AUST BE PRECEDED BY FULL REGULATORY OR I.S.C. IDENTIFY INFORMATION)  F 318  Continued From page 20 range of motion/stretch to both upper extremities to prevent contracture development. The RNA completed the training and signed the form on 1/26/11.  The review of the quarterly OT Screen deled 4/7/11 indicated Resident #96 was on a Restorative Range of Motion Program for the prevention of contracture management and OT evaluation was not indicated.  Review of the quarterly Minimum Data Set (MDS) dated 4/7/11 indicated Resident #96 was on a Restorative Range of Motion Program for the prevented the rasident was totally dependent on staff for all activities of daily living; and had range of motion limitations on one side of her upper extremities. There was no care plan completed for the resident's range of motion limitations.  The monthly Physician's Orders records (May 2011 and June 2011) for Resident #96 included: "may evaluate and place in Restorative Nursing Program(s) as appropriate".  During an observation on 6/7/11 at 9:43am, Resident #96 was observed in bed. The resident's range of motion limitations on one stife of the program			345051	B. WI		<u> </u>	06/1	0/2011
PRETIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  F 318  Continued From page 20  range of mollon/stretch to both upper extremitles to prevent contracture development. The RNA completed the training and signed the form on 1/28/11.  The review of the quarterly OT Screen dated 4/7/11 indicated Resident #96 was on a Restorative Range of Mollon Program for the prevention of contracture management and OT evaluation was not indicated.  Review of the quarterly Milmum Data Set (MDS) dated 4/7/11 indicated Resident #96 had short and long term memory problems with severely impaired decision-making skills. The MDS revealed the rosidont was totally dependent on staff for all activities of daily living; and had range of molton limitations on one side of her upper extremity and both sides of her tower extremities. There was no care plan completed for the residents range of molton limitations.  The monthly Physician's Orders records (May 2011 and June 2011) for Resident #96 included: "may ovaluate and place in Restorative Nursing Program(s) as appropriate".  During an observation on 6/7/11 at 0:43am, Resident #96 was observed in bed. The residents range of sight hand was tightly fisted. There were no splinting devices.  During an interview on 6/8/11 at 4:15pm, the Treatment Nurse revealed Resident #96 had			:NF		500	D MORVEN RD		
range of motion/stretch to both upper extremities to prevent contracture development. The RNA completed the training and signed the form on 1/26/11.  The review of the quarterly OT Screen dated 4/7/11 indicated Resident #96 was on a Restorative Range of Motion Program for the prevention of contracture management and OT evaluation was not indicated.  Review of the quarterly Minimum Data Set (MDS) dated 4/7/11 indicated Resident #96 had short and long term memory problems with severely impaired docision-making skills. The MDS revealed the resident was totally dependent on staff for all activities of daily living; and had range of motion limitations on one side of her upper extremities. There was no care plan completed for the resident's range of motion limitations.  The monthly Physician's Orders records (May 2011 and June 2011) for Resident #96 included: "may evaluate and place in Restorative Nursing Program(s) as appropriate".  During an observation on 6/7/11 at 9:43am, Resident #96 was observed in bed. The resident #96 was observed in Set. There were no spillning devices.	PREFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL	ULD BE	COMPLETION
that the resident was not in Restorative Nursing.  During an interview on 6/8/11 at 4:31pm, the	F 318	range of motion/streto to prevent contracture completed the training 1/26/11.  The review of the qua 4/7/11 indicated Resion Restorative Range of prevention of contract evaluation was not inc Review of the quarter dated 4/7/11 indicated and long term memon impaired decision-mal revealed the resident staff for all activities of of motion limitations o extremity and both sid There was no care pla resident's range of mo  The monthly Physician 2011 and June 2011) "may evaluate and pla Program(s) as approp  During an observation Resident #96 was obs resident's right hand w were no spilnting device  During an interview or Treatment Nurse reve contractures in both of that the resident was re-	th to both upper extremities a development. The RNA grand signed the form on a development. The RNA grand signed the form on a development and of the tree management and of the tree tree tree tree tree tree tree		318			

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OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1			
	345051	B. WING	***************************************	06/1	0/2011
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(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	DULD BE	(X5) COMPLETION DATE
Restorative Nurse stands and had never be Nursing Program.  During an interview of Nursing Assistant #1 #96 was semi-contract stiffen arms when tour resident was not receive range of motion and positioned every to the facility's Rehabilitation Resident #96 was not OT earlier this year for shoulders, elbows, writhe risk of contracture that when the resident completed in April, she ensure Restorative was requested by the Rehabilitation Manager ferrals to Restorative was resident is discharged restorative nursing as the therapy/restorative of this caregiver/aide to with the restorative nursing as the therapy/restorative nursing as the therap	ted that Resident #96 was en in the Restorative  on 6/10/11 at 10:14am, (NA#1) revealed Resident sted in both arms and would ched. NA#1 stated that the living therapy; but did on when she was turned 2 hours.  on, Resident #96 was with both arms crossed over the first of the living as living the lin living the living the living the living the living the living t		F431 Drug Records, Label, Store and Biological Nurse #2 received on-the-spot c	ounseling	7/8/2011
			and education regarding the pro	per	
	OF DEFICIENCIES F CORRECTION  ROVIDER OR SUPPLIER  OMMUNITY HOSPITAL S  SUMMARY STA, (EACH DEFICIENCY REGULATORY OR I  Continued From page Restorative Nurse sta not and had never be Nursing Program.  During an interview or Nursing Assistant #1 #96 was semi-contract stiffen arms when tour resident was not receive range of motion and positioned every and held to her chest.  During an interview or facility's Rehabilitation Resident #96 was not OT earlier this year for shoulders, elbows, worther risk of contracture that when the resident completed in April, shoulders, elbows, worther isk of contracture that when the resident completed by the Rehabilitation Manage referrals to Restorative was resident is discharge restorative nursing as the therapy/restorative of this caregiver/aide to with the restorative nursing as the therapy/restorative restorative Program.  483.60(b), (d), (e) DRI	ROVIDER OR SUPPLIER  OMMUNITY HOSPITAL SNF  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 21  Restorative Nurse stated that Resident #96 was not and had never been in the Restorative Nursing Program.  During an interview on 6/10/11 at 10:14am, Nursing Assistant #1 (NA#1) revealed Resident #96 was semi-contracted in both arms and would stiffen arms when touched. NA#1 stated that the resident was not receiving therapy; but did receive range of motion when she was turned and positioned every 2 hours.  On 6/10/11 at 10:20am, Resident #96 was observed in her bed with both arms crossed over and held to her chest.  During an interview on 6/10/11 at 12:14pm, the facility's Rehabilitation Manager revealed Resident #96 was not contracted, but received OT earlier this year for range of motion for shoulders, elbows, wrists and hands to prevent the risk of contracture development. She stated that when the resident's quarterly screen was completed in April, she did not double-check to ensure Restorative was providing the treatment requested by the Rehabilitative Department. The Rehabilitation Manager described the process for referrals to Restorative Nursing as: a week before a resident is discharged from therapy, the restorative nursing assistant would be trained on the therapy/restorative program. Upon completion of this caregiver/aide training, a written referral with the restorative nursing assistant signature would be sent to the nurse in charge of the	OF DEFICIENCIES F CORRECTION  (X1) PROVIDER/SUPPLIER (X2) MUI A BUILL 345061  ROVIDER OR SUPPLIER  OMMUNITY HOSPITAL SNF  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 21 Restorative Nurse stated that Resident #96 was not and had never been in the Restorative Nursing Program.  During an interview on 6/10/11 at 10:14am, Nursing Assistant #1 (MA#1) revealed Resident #96 was semi-contracted in both arms and would stiffen arms when touched. NA#1 stated that the resident was not receiving therapy; but did receive range of motion when she was turned and positioned every 2 hours.  On 6/10/11 at 10:20am, Resident #96 was observed in her bed with both arms crossed over and held to her chest.  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Upon completion of this caregiver/aide training, a written referral with the restorative nursing assistant's signature would be sent to the nurse in charge of the Restorative Program.  483.60(b), (d), (e) DRUG RECORDS,	OF DEFICIENCIES F CORRECTION  (X1) PROVIDER CAN SUPPLIER  (X2) MUNITIFIE CONSTRUCTION A, BUILDING B, WIMO  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUSTS BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (CONTINUED FROM PROSE BETTE AND OF CORRECT (EACH DEFICIENCY MUSTS BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (CONTINUED FROM PROSE BETTE AND OF CORRECT (EACH CORRECT WE ACTION SHE CROSS-REFERENCED TO THE APP DEFICIENCY)  (CONTINUED FROM PROSE RESIDENCY OR LSC IDENTIFYING INFORMATION)  (CONTINUED FROM PROSE RESIDENCY, STATE, ZIP CODE (EACH CORRECT WE ACTION SHE CROSS-REFERENCED TO THE APP DEFICIENCY)  (CONTINUED FROM PROSE RESIDENCY OR LSC INFORMATION SHE CROSS-REFERENCED TO THE APP DEFICIENCY)  (CONTINUED FROM PROSE RESIDENCY  (CACH CORRECT FROM PROSE RESIDENCY  (CONTINUED FRO	OF DEPICIENCIES FORRECTION  OF DISPRICIANCES FORRECTION  OF DISPRICATION NUMBERS 345061  DISPRICATION NUMBERS 345061  DISPRICATION NUMBERS 345061  DISPRICATION NUMBERS DISPRICAT

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345051	B. WIN	IG	· · · · · · · · · · · · · · · · · · ·	06/1	10/2011	
	ROVIDER OR SUPPLIER OMMUNITY HOSPITAL S	NF		STREET ADDRESS, CHY, STATE, ZIP CODE 500 MORVEN RD WADESBORO, NC 28170				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 431	a licensed pharmacist of records of receipt a controlled drugs in sur accurate reconciliation records are in order a controlled drugs is materially and biologicals labeled in accordance professional principles appropriate accessory instructions, and the eapplicable.  In accordance with Stafacility must store all docked compartments controls, and permit or have access to the key.  The facility must proving permanently affixed controlled drugs listed Comprehensive Drug and Control Act of 1976 and abuse, except when the package drug distributions.	toy or obtain the services of who establishes a system and disposition of all inclent detail to enable an any and determines that drug and that an account of all intained and periodically used in the facility must be with currently accepted and include the and cautionary expiration date when the area and Federal laws, the rugs and biologicals in under proper temperature only authorized personnel to a separately locked, compartments for storage of in Schedule II of the	i.i.	431	storage of medications.  Nurse #3 received on-the-spot cou and education regarding the proper labeling of medication. The Novol Insulin was immediately discarded replaced.  Medication carts have been inspecting a "dating who opened" to insure timely discard a appropriately labeled with "date of and a "date expires".  The Medication Administration Polyprocedure has been reviewed with Licensed Nurses who have been reeducated on this Policy and Procedincluding proper storage and labelic Each nurse has been given a copy of Policy.  The 7p-7a Nurses will conduct a we medication cart inspection using the monitoring tool that has been creatinglemented. This tool assures the multi-dose vials have a "date opened" date expires" on them and that no date medications are present in the	er in and cted to other en re pened" licy and the lure, ing. of the eekly ee ted and ot all ed" and o out of		
and the second	b <b>y</b> :	is not met as evidenced and staff interview, the sedications stored in a			medication cart. The Hospital Phar will review medications for approp- labeling and storage as well as com with other aspects of the Medication	riate pliance		

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345051	B. WAN	ıg_		06/	10/2011
	ROVIDER OR SUPPLIER OMMUNITY HOSPITAL S	NF		5	REET ADDRESS, CITY, STATE, ZIP CODE 600 MORVEN RD VADESBORO, NG 28170		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	lD PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D 8E	(X5) COMPLETION DATE
	locked area and falled insulin for 2 of 4 medicant for small nursing:  Findings include:  1. On 6/8/11 at 9:58ar preparing medication nurse placed the medication top of the medication the cart down the hall. The nurse placed her bank of windows in fro left the cart unattended top of the cart. There walking by the medication for Resident The medication for Resident The medication were in 10:02am until 10:09am picked up the medication Resident #24.  On 6/9/11 at 11:30am revealed that she was medication unlocked. If she did not remember top of the medication c2. The manufacturer's for Novolin 70/30 insulin. Vials should be discard whether refrigerated (3 or at room temperature Fahrenheit).	I to date an opened vial of cation carts. (medication station and for substation)  In Nurse 2 was observed for Resident # 24. The location in a medication cup on cart. The nurse pushed locking for the resident. In medication cart against a sort of the activity area and did with the medication on were residents and staff tion cart where the nut #24 were left unattended. In when Nurse #3 returned ion and gave them to  an interview with Nurse #3 trained to never leave further discussion revealed leaving the medication on mart. "I was nervous."  package insert instructions in dated 5/2010 included on regarding the storage of the insert indicated that led 28 days after opening 16-46 degrees Fahronheit) in (less than 86 degrees)	F. (1) (1) (1) (1) (1) (1) (1) (1) (1) (1)	431	Policy and Procedure, during week medication cassette exchanges. A discrepancies will be discarded an reported to a Nurse Manager.  The appropriate storage and label medication will be monitored by the Pharmacist and the Nursing Administration Team during the wind medication pass observations. Resthis monitoring will be reported to Director of Nursing weekly and will shared with the facility Quality Assessment and Assurance Commitmentially.	ing of he eekly sults of the I be	
		n observation with Nurse ge on the Medication Cart					

PRINTED: 06/24/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CUA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 345051 06/10/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **600 MORVEN RD** ANSON COMMUNITY HOSPITAL SNF WADESBORO, NC 28170 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 431 Continued From page 24 F 431 for the Substation found a multidose vial of Novolin 70/30 insulin open and undated. Nurse #3 stated that she labeled all insulin with the date opened when she opened them. She indicated that Insulin should be labeled with the open date to know how long you could use it. On 6/10/11 at 12:08 pm the Director of Nurses (DON) stated in an interview that nurses should know where and how to store medications as that was discussed during orientation. The DON also indicated that new nurses oriented with a seasoned nurse until familiar with all routines. If not sure where and how to store medications she revealed that a nurse was told to check with the nurse manager or call the pharmacist.

PRINTED: 07/12/2011 PEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO, 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDERVOUPPLIER/CLA (C) MULTIPLE CONSTRUCTION YAVINUE STAG (Q) COMPLETED IDENTIFICATION NUMBER: A. BUILDING CO HOSPITAL 02~ ANSON B. WING 345051 07/07/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, XIP CODE 500 MORVEN NO anson community Hospital snp WADESBORD, NGQUAVIRUCTION SECTION (X4) ID PREPIX TAG BUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL. REGULATORY ON LECTOENTIFYING INFORMATION) PROVIDERS PLAN OF CORRECTION ID GOMPLETION GOMPLETION DATE PREFIX YAG IEAGH CORRECTIVE ACTION STOULD UR CROSS-REFERENCED TO THE APPROPRICTE DEFIDIENCY) K 018 ~ The identified doors were K018 NFPA 101 LIFE SAFETY CODE STANDARD K 018 adjusted to latch on July 8, 2011. SS=D Doors protecting confdor openings in other than Doors throughout the facility were required enclosures of vertical openings, exits, or checked for similar conditions and hazardous areas are substantial doors, such as adjusted where necessary on 7/8/11 those constructed of 1% Inch solid-bonded core wood, or capable of resisting line for at least 20 Positive latching of doors will be added minutes. Doors in sprinklered buildings are only to our semi-annual safety survey for all required to resist the passage of smoke. There is patient care prepay for future periods no impediment to the closing of the doors. Doors are provided with a meens suitable for keeping Results of semi-annual surveys will the door closed. Dutch doors meeting 19.3.8.3.6 result in maintenance work orders to are permitted, 19,3,6,3 adjust, repair or replace non-latching Roller latches are prohibited by CMS regulations doors or door hardware where door In all health care facilities. are found not positively latching. The next survey is scheduled for December. 2011. K 029 - Door closers were ordered and installed on the three doors identified during the survey with work completed This STANDARD is not mat as evidenced by: on July 29, 2011. A. Based on observation on 07/07/2011 the All other doors to one hour rated following doors falled to latch when closed, #30. #23 and #18. compartments were checked for the K 028 NFPA 101 LIFE SAFETY CODE STANDARD K 029 need for door closers and one \$\$¤D One hour fire rated construction (with 1% hour additional door was equipped with fire-rated doors) or an approved automatic fire closer as a result. This condition will extinguishing system in accordance with 8,4,1 also be monitored during semi-annual and/or 19.3.5.4 protects hazardous areas, When the approved automatic fire extinguishing system safety surveys, option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or LABORATORY DIRECTOR'S OR PROPRIETED PLIER REPRESENTATIVES SIGNATURE TITUS TAN (NK) OB President

Any delidency distanced ending with an enterisk (") denotes a delicionary which the institution may be excussed from considing it is determined that officer soluguands provide sufficient protection to the patients. (See instructions.) Except for numbing homes, the findings sixted above are disclossible 90 days following the date of survey whicher or not a plan of correction is provided. For numbing homes, the above findings and plans of correction are disclossible 10 days following the date these decuments are made available to the facility. If delicionder are viled, an approved plan of consistents requisits to continued program puddiapillan.

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ave about		A MEDIONID CLICATORO				OMB NO. OBSB-03B1		
Statement of Deficiencies and Plan of Conrection		(X1) PROVIDERIGUPFLIERICUA IDENTIFICATION NUMBER:	(X2) N A. BU		ple Construction U 02 - Anson Cu Hospital	OCS) DATE SURVEY COMPLETED		
***		346051	0. WI	o. wing		07/07/2011		
ANSON	This STANDARD is not met as evidenced by A Based on observation on 07/07/2011 the to the laundry did not close and latch.  C. The soiled linen elso falled to close are displayed in Exit and directional signs are displayed in Exit and directional signs are displayed in			po	eet addhess, city, state, 2/p code 10 morven ro (ADESBORO, NG 28170			
PREFIX	HEGITYLOU OU TRO IDEALITAING INFOUWALION)  HEGITYLOU OU TRO IDEALITAING INFOUWALION)  HEGITYLOU OU TRO IDEALITAING INFOUWALION)		ID PREFIX TAG		DEFICIENCY)  PROVIDERS PLAN OF CONTEC (EACH CORRECTIVE ACTION BHO (EACH CORRECTIVE ACTION BHO (EACH CORRECTIVE ACTION BHO (EACH CORRECTIVE ACTION OF THE APP)	HOULD HE COMPLETION		
K 029	field-applied protective plates that do not exceed 48 Inches from the bottom of the door are		K 028		K 047-Two Exit signs for each courtyard not so equipped have been ordered and will be installed on emergency power by August 9, 2011, The facility has been reviewed and egress lighting will be replaced in the			
	A Based on obsert to the laundry did not the laundry did not be. The door to the sub-station falled to C. The soiled linen also NFPA 101 LIFE SAI Exit and olirectional accordance with secondance with second	valion on 07/07/2011 the door of close and latch, to lose and latch latch, to lose and latch latc	Κо		older courtyards to provide of egress lighting at each of with an exit sign by 8/9/1. Maintenance of these light added to the building main program and will be insperance of these lights a linduded on our semi-annual surveys.	le two sou exit provid 1, its has bee ntenance cted re viso	rces ed	
K 056 88+D	A. Basad on obsery facility has inree (3) have illuminated exit exiting the court yar. NFPA 101 LIFE SAF If there is an automatical line in the instelled in accordant for the instelled complete to building. The system	ETY CODE STANDARD  It sprinkler system, it is co with NFPA 13, Standard Sprinkler Systems, to verage for all portions of the 1s property maintained in PA 25, Standard for the	<b>K</b> 0	56	K 056 — A high/low pressubeen added to the older d system. It was connected talarm system and tested fron July 2B, 2011, it has becour sprinkler system maint program and our fire alarm testing and inspection program; and country regular testing. All testing documented.	ry sprinkle to the fire or operati en added t tenance n system gram for	r on	

AUG-01-2011(MON) 16:23 Anson Comm Hosp-2nd F1r Finance (FAX)704 695 3263
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

P, 004/005 FORM APPROVEO OMB NO, 003B-0381

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STATEMENT OF DEFICIENCIES AND PLAN OF CONNECTION		(X1) PROVIDENSUPPLIENCLIA IDENTIFICATION NUMBER:	VS) WAITUSTE CONSTRUCTION  OS - VANZON CO HORBITAT			COMPLETED  (X3) DAYE SURVEY		
345051		345051	B, W	NING		07/07/2011		
ИОВИА	PROVIDER OR BUPPLIER GOMMUNITY HOSPI)			301	etadoress, dny, state, zip code I morven RD NDESBORO, NC 28170	,		
DA) (U PREFIX TAG	Bummary Syatement of Deficiencies (Fach Deficiency must be preceded by Full, Regulatory or LSC Identifying Information)		ID PREFIX YAU		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	SHOULD BE COMPLETION		
	Continued From page 2 Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required aprinkler systems are equipped with water flow and temper switches, which are electrically connected to the building fire alarm system. 19.3.5  This STANDARD is not met as evidenced by: A. Based on observation on 107/07/2011 the dry sprinkler system for the older section of the building did not have a supervised high and low air pressure switch.			K 062 - Celling spray on identified sprinkler head was removed on July 15, 2011.  Sprinkler heads throughout facility were inspected for similar condition and those found were also cleaned.  This inspection will also be added to the semi-annual safety surveys.  The next semi-annual survey is scheduled for December 2011.			ere	
S\$=D	Required automatic continuously mainta condition and are in	FETY CODE STANDARD  sprinkler systems are ined in rollable operating spected and losted 6, 4.8.12, NFPA 13, NFPA	K	62	K 072 — The identified doo equipped with a UL Listed on July 29, 2011. The facility was surveyed t deficiencies and none wer	door close or any sim e found.		
K 072	This STANDARD is not met as evidenced by: A. Besed on observalion on 07/07/2011 the condor sprinkler head near room 31 had been painted (head must be replaced). NFPA 101 LIFE SAFETY CODE STANDARD  Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of the or other emergency. No furnishings, deconstons, or other objects obstruct exils, access to, egress from, or visibility of exits. 7.1.10		K 072		Operation of closers and pos- latching hardware will be mo during semi-annual safety su next scheduled semi-annual s survey is scheduled for Decei			

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 07/12/2011 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED Statement of deficiencies (X1) PROVIDENSUPPLIENCUA IDENTIFICATION NUMBER: 16E0-8E80 'ON BWO AND PLAN OF CORRECTION DES MULTIPLE CONSTRUCTION (CX) DATE BURVEY COMPLETED akiquiua 🗡 UZ-ANSON CO HOSPITAL D. WHG_ 345051 NAME OF PROVIDER OR SUPPLIER 07/07/2011 BTHEET ADDRESS, CITY, STATE, MP CODE Anson Community Hospital SNF **SUB MORVEN RD** WADESBORD, NC 28170 RIMMANY STATEMENT OF DEFICIENCIES [EACH DEFICIENCY MUST BE PRECEDED BY FULL, REGULATORY OR LSC IDENTIFYING INFORMATION] (X4) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION CONCLETION (XX) PREFIX (EACH CORRECTIVE ACTION BHOULD BE CHOSE-REFERENCED TO THE APPROPRIATE DEPICIENCY) **ገ**ለር K 072 Confinued From page 3 K 072 This STANDARD is not mot as evidenced by: A. Based on observation on 07/07/2011 the door to Jankors aloset #51 opened into the corridor but not 180 degrees, thus reducing the width of the confider. This door must be equipped with a lieted closer. K 147 NFPA 101 LIFE SAFETY CODE STANDARD K 147 \$59D Electrical wiring and equipment is in accordance K 147 - Protective lamp sleeves were with NFPA 70, National Electrical Code, 9.1.2 'installed on the identified light fixtures on July 8, 2011, The facility was inspected to identify This STANDARD is not met as evidenced by: any additional occurrences, and where A. The solled linen room near room 51 had exposed bulbe in the light fixtures. found, this condition was also B. The med, refrigerator in the storage room hear corrected. room 20 was not connected to an emergency This item will be added to the semialmuit C. The facility is to verify that some of the count annual safety surveys. yard light between are on emergency power. The next semi-annual survey is 42 CFR 403,70 (a) scheduled for December 2011.

FORM CLIS-2507(02-09) Provious Vanions Obsolute

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Il continuation sheet Page 9 of 4